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ABSTRACT

Adolescent suicide has tripled in the past two decades and is considered to be a leading cause of death among America's youths. This increase has prompted much research on the assessment and prevention of adolescent suicide. Suicidologists have agreed there are no scientifically proven methods to assess which individual might attempt suicide. However, there are specific risk factors and warning signs that can provide valuable information about an adolescent's potential for suicide. The challenging task for parents, educators, physicians, mental health workers and other care givers of adolescents is to use this information to create a model for prevention of suicide that empowers at-risk youth to begin the process of healing. This paper reviews the current research on adolescent suicide, provides information about the risk factors and warning signs, discusses the clinician's role and responsibility in suicide assessment, and reviews current suicide prevention efforts. Contains 22 references. (Author)

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Adolescent Suicide Assessment and Prevention:

Empowerment for Life

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Abstract

Adolescent suicide has tripled in the past two decades and is considered to be a leading cause of death among America's youths. This increase has prompted much research on the assessment and prevention of adolescent suicide. Suicidologists have agreed there are no scientifically proven methods to assess which individual might attempt suicide. However, there are specific risk factors and warning signs that can provide valuable information about an adolescent's potential for suicide. The challenging task for parents, educators, physicians, mental health workers and other adolescent caregivers is to use this information to create a model for prevention of suicide that empowers at - risk youth to begin the process of healing. This paper reviews the current research on adolescent suicide; provides information about the risk factors and warning signs; discusses the clinician's role and responsibility in suicide assessment; and reviews current suicide prevention efforts.

Adolescent Suicide Assessment and Prevention: Empowerment for Life

Adolescent suicide is increasing at an alarming rate in the United States with experts differing on the actual statistical data pertaining to the prevalence of suicide among youths (Brunelle, 1990; Hoff, 1995; Morrissey, 1994; Sargent, 1989; Blumenthal, 1990; Henry & Stephenson, 1994). Many researchers (Brunelle, 1990; Hoff, 1995; Morrissey, 1994; Sargent, 1989) report that suicide is the second leading cause of teen deaths while others (Blumenthal, 1990; Henry & Stephenson, 1994) believe it to be the third leading cause of adolescent deaths after accidents and homicides.

Data is fairly consistent regarding the number of youths who are attempting and completing suicide. Between 300,000 and 600,000 teens attempt suicide each year (Hoff, 1995; Morrissey, 1994; Sargent, 1989) with approximately 6,000 successfully completing the act (Henry & Stephenson, 1994; Sargent, 1989). Further research (Brunelle, 1990; Foster, 1996; Lazar, 1993; Garland & Zigler, 1993) showed adolescent suicide rates to be approximately 11 per 100,000. While Morrissey (1994) considers these statistics to be epidemic, Garland and Zigler (1993) stated "suicide is still relatively rare, with a rate of 11.3 per 100,000 among 15 - 19 year olds" (p. 174).

Whether one considers these statistics to be rare or epidemic, the tragedy of adolescent suicide is a reality. Adolescents in America are attempting and completing suicide every day using such lethal means as gassing, hanging,

ingestion of substances and, the most lethal of all, the use of firearms. While more females than males attempt suicide (Blumenthal, 1990), males are more successful at completing suicide because of the methods chosen in their suicide attempts (Hoff, 1996; Lazar, 1993). Females are more likely to choose less lethal methods such as gassing and ingesting substances while males often choose firearms and hanging (Garland & Zigler, 1993). The National Association for the Education of Young Children in its State of America's Children Yearbook (1995) reported there were 5,367 firearm deaths among children from 1 - 19 years of age in 1994 with at least 1500 of these deaths from suicide. Handguns were used in about " 70 percent of all adolescent suicides in which a firearm [was] the suicide weapon" (National Association for the Education of Young Children, 1995, p. 58).

This statistical data supports the need for information and education regarding the appropriate diagnosis and treatment of adolescent suicide as well as a need for effective preventive programs in schools and communities. This paper will provide the reader with recent research on adolescent suicide including lists of key risk factors and observable warning signs that can provide essential information regarding the adolescent's potential for suicide. Research will also be provided that supports the collaboration between youth, families, schools, communities, law enforcement officials, and mental health workers for the creation of effective suicide prevention programs.

Suicide Research

Adolescents who commit suicide " not only prefer death over life, but they are telling us in powerful behavioral language that they don't even want to try out the society that we have created for them" (Hoff, 1995, p.204). In fact, suicide is considered to be a powerful means of communication by people who have had a history of unsuccessfully communicating (Hoff, 1995). Edwin Schneidman (as cited in Responding to Someone, 1995), a suicide expert at the University of California at Los Angeles School of Medicine, reported "only about 4 or 5 percent of people who talk about suicide do it ... but it's also true that 90 percent of those who commit suicide did talk about it" (p.8A).

The major question for society to consider is why would adolescents with their whole life ahead of them choose death over life? Adolescence is a challenging time when teens are attempting to master developmental tasks and are often expected to make adult decisions when faced with adult experiences without the necessary resources (Sargent, 1989). These challenges result in an imbalance where adolescents consider life to be an either / or situation which results in the adolescent becoming polarized within their family or community (Sargent, 1989). The adolescent then begins to feel totally isolated and becomes hopeless, hapless and helpless which in turn can lead to the decision life is not worth living (DeWild, Ineke, & Kienhorst, 1993; Ellis, 1995; Hoff, 1995).

Ellis (1995) concurred with these researchers and further stated that people strive for a "balance or equilibrium between various aspects of their personality"

(p.1). If events or thoughts upset this balance, the individual can be motivated to change but, often times, the process is more destructive as the individual's attempts to change are unsuccessful. This may be the beginning of the process of suicide, as the adolescent narrows his or her choices down to only one option - death (Ellis, 1995).

Suicide Prediction

There still remains the question of who exactly is at risk for suicide and can suicide be scientifically predicted? Motto (as cited in Hoff, 1995) stated that suicide prediction was not very useful or precise and "should probably be eliminated from scientific terminology" (p. 189). Some researchers (Blumenthal, 1990; Morrissey, 1994; Hoff, 1995) advocate the observation of warning signs and risk factors for suicide prediction, while others (Garland & Zigler, 1993) believe although it is important to recognize and identify risk factors, they are not very accurate in predicting an individual's suicidal behavior. Porkorny and Goldstein (as cited in Hughes, 1995) performed two of the largest and most sophisticated empirical investigations in an attempt to predict suicide and concluded that suicide is not predictable. Predictable or not, this does not eliminate the responsibility of the mental health worker to do an appropriate suicide risk assessment which can increase the likelihood of preventing a suicide (Hughs, 1995).

Clinical Assessment

A successful therapeutic intervention with suicide attempters, combined with the clinician's ability to assess the suicidal risk, are critical factors in the

prevention of suicide (Garland & Zigler, 1993). It is essential for clinicians to become trained in assessing suicide; be vigilant in recognizing the warning signs; and provide supportive interventions, alternative choices, and appropriate treatment for suicidal adolescents (Blumenthal, 1990). Clinicians also need to be aware not all clients communicate their intent to commit suicide and understand the importance of a comprehensive mental examination that can explore their clients feelings of depression and thoughts of suicide (Aro, Heikkinen, Henriksson, Lonnqvist & Marttunen, 1995).

Successful assessment and treatment will depend on the clinician's ability to incorporate knowledge of suicidal risk factors into a coherent plan for careful evaluation and case management of the adolescent (Blumenthal, 1990). This is accomplished through effective interviewing where the clinician: assesses the adolescent's presenting complaint; review's history of physical and emotional illness; explores the family history of medical illness, psychiatric disorders and / or substance abuse; assesses family functioning; administers a Mental Status Examination; and refers the adolescent for a physical examination and necessary laboratory testing (Blumenthal, 1990).

One of the most critical factors in the process of clinical assessment and treatment of the suicidal adolescent is the development of a positive therapeutic alliance between the clinician, the adolescent, and the family (Blumenthal, 1990). Important to this alliance is the clinician's ability to assess the suicidal risk from the

perspective of the adolescent without letting his or her own views of suicide interfere with the therapeutic process (Sargent, 1989).

If the risk of suicide is moderate or low, the clinician can assist the youth through outpatient counseling and treatment; but if the adolescent's risk of suicide is assessed to be high, there may be the need for a more aggressive therapeutic intervention such as psychiatric hospitalization (Sargent, 1989). Hoff (1995) has argued that hospitalization may promote, rather than prevent, suicide and committing a suicidal person involuntarily to a psychiatric facility "attacks the person's sense of dignity and self - worth, increases the person's sense of abandonment, and gives the suicidal person one more reason to choose death over life" (p. 176). However, this does not mean that it is not essential to clinically treat the adolescent who is at high risk. Correctly identifying, assessing, and treating psychiatric disorders is a key element in preventing adolescent suicide (Blumenthal, 1990).

Risk Factors

What are the risk factors of adolescent suicides? The most powerful prediction of adolescent suicide is a prior history of suicide attempts with up to 40 % of attempters making more attempts (Blumenthal,1990; Garland & Zigler, 1993). Many researchers (Blumenthal, 1990; Brunelle, 1990; Garland & Zigler, 1993; Groze & Proctor, 1994; Henry & Stephenson, 1994; Hoff, 1995; Lewis & Lewis, 1996; Morrissey, 1994) have agreed there are several key risk factors in

addition to prior attempts that can identify adolescents who may be at risk of committing suicide. These risks include: drug and alcohol abuse; antisocial or aggressive behavior; affective illness such as depression or manic depression; broken family systems or communication breakdown in the family; lack of a significant adult in the youth's life; family history of suicidal behavior; and the availability of a firearm (Garland & Zigler, 1993).

Other risk factors include sex and age with 70% of suicides being young white males (Blumenthal, 1990); sexual identity confusion (Garland & Zigler, 1993) with researchers reporting that gay and lesbian youths are three times more likely to commit suicide (Groze & Proctor, 1994); a recent loss of or separation from a loved one (Ellis, 1995); long - standing family dysfunction (Lewis & Lewis, 1996); poor cognitive or social development (Lewis & Lewis, 1996); high parental and individual expectations (Henry & Stephenson, 1994); school problems (Garland & Zigler, 1993); emotional, sexual or physical abuse (Garland & Zigler, 1993); a shameful or humiliating experience (Garland & Zigler, 1993); communication problems (Hoff, 1995); and feelings of isolation (Brunelle, 1990; Hoff, 1995).

Other areas that have prompted further research in their relation to suicide risk are the neurochemical and biochemical factors of suicide (Blumenthal, 1990), the incidence of cluster or copycat suicides (Lazar, 1995), and the role media plays in cluster suicides (Lazar, 1995). Research has shown there is a high correlation

between depression and a person's lowered level of the neurotransmitter serotonin. (Blumenthal, 1990). Decreased hormone secretions and decreased corticotropin releasing factor have also been linked to depression which is a major risk factor of adolescent suicide (Blumenthal, 1990).

Dr. John Mann (as cited in Lazar, 1995), a psychiatry professor at Columbia University, has done extensive research on the effects of lower levels of serotonin in relation to depression and suicide. Dr. Mann (as cited in Lazar, 1995) has reported that because serotonin regulates the body's aggressive and impulsive behavior, drugs such as Prozac and Zoloft could be effective in the treatment of adolescent depression which in turn could reduce the risk of suicide. Dr. Mann (as cited in Lazar, 1995) is currently developing a technique called brain imaging that will produce detailed images of the brain's workings and allow psychiatrists to run a serotonin test similar to the way technicians now do X - rays.

Adolescents have a greater tendency to imitate and be impulsive which is evidenced in cluster suicides (Hoff, 1995). While cluster suicides only account for 1-2% (Lazar, 1995) of all U.S. suicides per year, they are still real (Blumenthal, 1990). Madelyn Gould (as cited in Lazar, 1995), an epidemiologist at Columbia University who studies and researches cluster suicides, believes adolescents see suicide as an option without being cognizant of the pain of the suicide. Gould (as cited in Blumenthal, 1990) has "proposed an infectious disease model to explain the contagion that appears to operate in suicide clusters" (p. 528).

Mass media plays a significant role in increasing the risk of cluster suicides by romanticizing and sensationalizing suicide (Blumenthal, 1990; Garland & Zigler, 1993) with suicide risk increasing if media reports last for several days after a true suicide (Henry & Stephenson, 1994). Contagion is not a primary cause of suicide but it might have the potential to decrease the threshold for action among at - risk adolescents (Lewis & Lewis, 1996).

While it is important to consider risk factors when assessing an adolescent's potential for suicide, Hoff (1995) cautioned against relying solely on these risk factors as a criterion for potential suicide as it is also essential to look at the patterns of the signs, using clinical judgment as well as data to evaluate the risk of suicide. Included in this assessment should be the observance of any warning signs that might indicate the adolescent is considering suicide as an option (Hoff, 1995).

Warning signs

Just as there are specific factors that can put an adolescent at risk for suicide, there are also a number of signs that can serve as warnings for those who are working with adolescents who may be at risk of attempting suicide. The American Association of Suicidology (AAS) (as cited in Morrissey, 1994) reported these warning signs to include: talking about committing suicide; having trouble eating or sleeping; withdrawing from friends or social activities; losing interest in hobbies, school or work; preparing for death by making out a will and

final arrangements; giving away prized possessions; having attempted suicide before; taking unnecessary risks; having had a recent severe loss; being preoccupied with death and dying; losing interest in personal appearance; or increasing their use of alcohol or drugs.

One other warning sign that appears confusing to observe in some adolescents is depression (Morrissey, 1994). While adolescent depression can be characterized by symptoms such as sadness, low level of functioning, or despondency (Morrissey, 1994), David Capuzzi (as cited in Morrissey, 1994), author of Suicide Prevention in the Schools: Guidelines for Middle and High School Settings, described other adolescent symptoms of depression such as anger, drug abuse, defiance towards perceived authority, truancy, or running away.

Collaborative Efforts

Knowledge and assessment of risk factors as well as the observation and reporting of warning signs cannot guarantee the prevention of all adolescent suicides, but they can be valuable tools in the prevention process. The information about risk factors and warning signs can assist parents, teachers, family doctors, youth workers, law makers, and young people as they work collaboratively towards the assessment and prevention of adolescent suicide (Hoose, 1995). Blumenthal (1990), Foster (1996) and Sargent (1989) have noted the importance of creating a therapeutic alliance between schools, community, family, mental health workers, and friends. David Capuzzi (as cited in Foster, 1996), also

reported that collaboration is a key component in preventing children from being placed at risk.

Wilson (as cited in Foster, 1996) placed a stronger emphasis on the community by stating "if the community at large is part of the problem, it must also be part of the solution" (p.21). Sargent (1989) expanded Capuzzi's statements to include the school and believed that because "adolescence is a time of separation and individuation, community and school programs can be [more] effective in reaching parents and teens" (p. 3). While there is no clear research to support which element of the collaborative effort to prevent adolescent suicide is more important, research does support the importance of a collaborative effort among community members in the success of adolescent suicide prevention programs (Hoff, 1995; Foster, 1996; Sargent, 1989).

Suicide Prevention Programs

Blumenthal (1990) and Garland and Zigler (1993) have proposed similar programs that can work collaboratively towards the prevention of adolescent suicide. Garland and Zigler (1993) have proposed effective prevention programs to include:

> Integrated primary prevention programs [school and family support services]
> Suicide prevention education for professionals
> Education and policy formation on firearm management
> Education of media professionals about the social imitation factor in adolescent suicide

More efficient identification and treatment of at - risk youth
Crisis intervention and postvention programs (p. 177).

Blumenthal (1990) has suggested programs to include:

Education to decrease alcohol and substance abuse

Education to increase public awareness of depression

Community clinics for at - risk youths

Increased education for clinicians about diagnosis and treatment of depression and suicidal behaviors

Decreased barriers to treatment for young people

Increased insurance benefits for psychiatric disorders and substance abuse (p. 543).

Another suicide preventive program that has grown in recent years is crisis hotline services (Lazar, 1995). As early as 1957, Schneidman and Farberow (as cited in Garland & Zigler, 1993) formulated the rationale for crisis hotlines by reporting their belief that suicidal behavior is often associated with a crisis situation where the adolescent often experiences ambivalence about living and dying. Schneidman and Faberow (as cited in Garland & Zigler, 1993) argued, because human beings have a basic need for interpersonal communication, adolescents who feel hopeless and isolated may utilize the hotlines in an effort to communicate with others.

These hotlines are usually staffed by adult volunteers but some are run by adolescents as peer helpers (Lazar, 1995). Regardless of who is volunteering to answer these crisis hotlines, it is essential to provide adequate back up support from mental health services and to reveal to callers anonymity can not be

guaranteed because emergencies may require intervention by professionals (Garland & Zigler, 1993).

It is important that this policy of providing supervision by trained mental health professionals apply not only to crisis hotlines but to all peer helper programs in schools and the community (Lewis & Lewis, 1996). Richard E. Nelson (as cited in Responding to Someone, 1995), co-author of the 1994 book, The Power to Prevent Suicide: A Guide for Teens Helping Teens, reported teens need to realize the importance of referring their peers for appropriate services and states "it is always better to act, even if you find out later that the person didn't need help ... [because] saving a life is a serious matter" (p. 9A).

Suicide Prevention Program Effectiveness

Professional suicidologists (those trained in the study of suicide and suicide prevention) believe that suicide prevention is everybody's business. This can be a difficult task considering the false beliefs or myths there are about suicide (Hoff, 1995). These myths about suicide include: talkers never commit suicide; there is often no warning of the suicide; suicidal people want to die; talking about suicide will cause it; once a person is suicidal, they will always be suicidal; only a certain class of people commit suicide; suicidal people are insane; improving the suicidal person's emotional state will lessen the risk of suicide; and suicidal tendencies are inherited (Brunelle, 1990; Ellis, 1995).

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While suicidologists agree that these statements about suicide are totally without any basis of truth, they do believe there are many difficulties in attempting to learn more about people who could be self - destructive (Hoff, 1995). Some of these difficulties include the limitations of doing research on people; societal feelings about suicide and other self - destructive acts; cultural taboos against suicide; and the difficulty that arises from examining the suicide from the reports of the suicide survivors (Hoff, 1995).

These difficulties contribute to the almost impossible task of assessing the effectiveness of preventive methods as they hamper researchers in their collection of necessary empirical data needed to adequately determine preventive program effectiveness (Foster, 1996; Garland & Zigler, 1993; Hughes, 1995; Lewis & Lewis, 1996). The National Center for Disease Control (as cited in Lazar, 1995) stated in a 1992 report that all they could defend scientifically was that preventive programs may or may not prevent youth suicide (Lazar, 1995). In fact, some efforts such as the peer helper programs (Lazar, 1995; Lewis & Lewis, 1996) and curriculum based school prevention programs (Garland & Zigler, 1993; Sargent, 1989) have even been found to have a negative affect on the potentially suicidal youth.

Garland and Zigler (1993) support criticisms of programs that promote suicide from a stress model rather than a mental illness model. While "the rationale behind this approach is that the destigmatization of suicide will encourage students

who are feeling suicidal to identify themselves and to seek help" (Garland & Zigler, 1993, p.174), the reality is that this destigmatization can actually normalize the suicidal behaviors (Garland & Zigler, 1993). It is possible for these well - intentioned programs to increase the risk of suicide "because they (a) normalize suicide by de-emphasizing the role of mental illness and erroneously portraying suicide as a reaction to common stressors, (b) overstate the frequency of adolescent suicides and create strong identification with suicide attempters and completers ... and (c) stimulate hopelessness and saliency of suicide among at - risk individuals" (Lewis & Lewis, 1996, p. 307).

A concern for school - based prevention programs is that these types of programs don't always reach the adolescent most at risk such as drop outs, runaways, or those incarcerated (Hoff, 1995). This is an area where community preventive efforts might be best utilized (Foster, 1996).

> It is essential for further suicide prevention efforts to be based on empirical data such as that reported by Porkorny and Goldstein (as cited in Hughs, 1995) that can help identify children who may be at risk for suicide and assist in referring the adolescent to the most effective therapeutic interventions. Last, it is critical that these preventive programs have a sound theoretical foundation as well as professional support and advice to avoid secondary negative effects (Sargent, 1989).

Discussion

The review of the literature on adolescent suicide assessment and prevention is convincingly clear this is a very complex issue involving a multitude of factors. Factors include the ability for adolescent caregivers to assess the risks and warning signs of suicide and be willing to undertake the challenging task of creating a safe environment for mutual dialogue while facilitating change (Lazar, 1995). A second factor would be the creation of an environment that will provide youths with the opportunity to communicate their needs and be heard by the caring adults within their community (Responding to Someone, 1995). This dialogue is essential because isolation from their families, friends, and community has been proven to be a predominate factor in the destructive cycle of adolescent suicidal behaviors (Hoff, 1995). Adolescents will adjust in positive ways when they are supported in their search for meaning, taught tools for self - expression, and ultimately learn they are responsible for their own happiness.

Additional factors in assessment and prevention of adolescent suicide include legislative action and the media. Legislators must recognize the impact and influence their policy making procedures have within their communities (Garland & Zigler, 1993). Legislators can empower communities by designating funds for prevention programs and encouraging research on adolescent self - destructive behaviors. Generating funding and exploring empirically based data are crucial to the planning and implementation of suicide prevention programs (Hughs, 1995).

The local media must educate itself and provide socially responsible reporting aimed at preventing rather than perpetuating adolescent suicides (Lazar, 1995). Research has shown that glamorizing and romanticizing the tragedy of young people choosing death over life - suicide - has devastating effects on the entire community (Garland & Zigler, 1993; Hoose, 1995). Inappropriate responses to traumatized communities by those in a position to facilitate change tend to promote further isolation and hopelessness while sabotaging preventive efforts (Hoff, 1995). Media can provide powerful communication and educational tools to positively influence cultural perspectives and views of adolescents at risk. Positive perspectives that will be invaluable for the creation and support of effective preventive programs.

Preventive methods must include collaboration of youth, mental health workers, families, physicians, educators, community members, law makers, corrections officials, and other support agencies who focus on proactive youth development (Foster, 1996: Hoff, 1995). These collaborative proactive prevention programs are critical to the process of fostering community dialogue, assessing services for at - risk youth, accessing skilled caregivers and facilitators, and planning and implementing systemic change.

Conversations about adolescent suicide can only happen if someone is willing to ask the questions in an empowering and structured environment. Information collection and community education are critical components of this

proactive approach to prevention as they assist in dispelling the social stigma and false myths about suicide. A necessary process that needs to occur if any preventive efforts are to be successfully supported and implemented.

A thorough assessment of services for at - risk adolescents will identify and influence the views of skilled caregivers and facilitators as well as others who need to be involved with the collaborative approach of prevention. This assessment will allow for the further development and refinement of programs and services that are critical to the preventive process of adolescent suicide.

Last, systemic change is necessary to meet the needs of at - risk youths and the individuals within the community who support proactive prevention efforts. Only through change can society begin the process of growth. Growth through a collaborative proactive approach will empower the development of community's most valuable resource - vulnerable but invincible children.

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